U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 03 March 2005

CASE NO.: **2004-BLA-05201**

In the Matter of:

BLAIN RUSSELL,
Claimant,

v.

ARCH OF WYOMING, L.L.C.
c/o ARCH COAL, INC.
c/o UNDERWRITERS SAFETY & CLAIMS,
Employer/Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest.

Appearances: Keith S. Burron, Esq.
For the Claimant

Catherine McPherson, Esq.
For the Employer

Before: RICHARD K. MALAMPHY
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act" or "the BLBA") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

A formal hearing was held before me in Rawlins, Wyoming on June 23, 2004. At that time, both parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations. Director's exhibits 1-28, Employer's exhibits A-S and Claimant's exhibits 1-9 were admitted into evidence at the hearing. (Tr. 5, 13-15, 65).[2] Additionally, Claimant has submitted the July 21, 2004 letter of Dr. John Glode as Claimant's exhibit 10, and Employer has submitted the reading by Dr. Repsher of the April 28, 2004 x-ray as Employer's exhibit T, both of which are hereby admitted into evidence as labeled.

Issues

The following issues are presented for resolution:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled; and,

4. Whether the Miner's disability is due to pneumoconiosis.

(DX 26, Tr. 15).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

Findings of Fact and Conclusions of Law

Procedural Background

The Claimant filed his application for benefits on May 2, 2001. (DX 2). It was granted by the Director, Office of Workers' Compensation Programs, in a Proposed Decision and Order dated March 7, 2003. (DX 20). Employer filed a timely request for a hearing and this matter was referred to the Office of Administrative Law Judges on October 29, 2003. (DX 22, 26).

[2] The following abbreviations are used herein: "DX" refers to the Director's Exhibits and "Tr." refers to the transcript of the June 23, 2004 hearing.

Background

The Claimant was born on August 9, 1936, and he has an eighth grade education. (DX 2). He married Beverly Zator on May 11, 1974 and she is his sole dependent for purposes of augmentation of benefits. (DX 2, 6, Tr. 48). The Claimant's wife also testified at the hearing, regarding her husband's conditions and treatment.

The Claimant testified that he began smoking at the age of twenty-five years and that he smoked at the rate of a carton a month. (Tr. 21, 41). He denied that he ever smoked three packs per day. (Tr. 21). He quit smoking sometime around 1991. (Tr. 21). The Claimant testified that he has heart problems, having suffered a heart attack and undergone angioplasty. (Tr. 22). He also suffers from high blood pressure. (Tr. 23). He quit his employment as a coal miner after suffering a back injury. (Tr. 38). He receives Social Security disability benefits because of his back injury. (Tr. 38).

Length of Coal Mine Employment

The parties have stipulated to twenty-two years of coal mine employment and I so find. (Tr. 15). The Claimant worked as a heavy equipment operator while employed by Arch of Wyoming, ceasing his coal mine employment in 1998. (Tr. 36).

Responsible Operator

Arch of Wyoming does not contest that it was properly designated the responsible operator herein. (Tr. 16). The evidence supports such a finding, and accordingly, I find that Arch of Wyoming is the properly designated responsible coal mine operator in this case.

Applicable Law

Because this claim was filed after the enactment of the Part 718 regulations, entitlement to benefits will be evaluated under the Part 718 standards. 20 C.F.R. § 718.2. In order to establish entitlement to benefits under Part 718, the Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) he suffered from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is due to pneumoconiosis. It is Claimant burden to establish entitlement by a preponderance of the evidence. *See generally Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994); *see also 20 C.F.R. §§ 718.201 – 718.204*. Failure to establish any one of the necessary elements precludes entitlement. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986).

Medical Evidence

X-ray Readings

The following chest x-ray readings have been submitted.

Ex. No.	Date of X-ray	Physician/Qualifications[3]	Impression
DX 12	8/21/01	Webber BER	no pneumo
DX 13	8/21/01	Preger B BCR	Quality 1
EX D	10/6/03	Walker	mild pulmonary hypertension
EX B	10/6/03	Repsher B	no pneumo
CX 1	4/28/04	Lynch B BCR	s/t 1/0
EX T	4/28/04	Repsher B	no pneumo

Chest x-rays taken during the Claimant's hospitalizations are in the record. (DX 14, EX L, O, P). They were not read for the purpose of classifying pneumoconiosis and are silent as to the disease. Therefore, for the most part, they will not be set forth herein. A chest x-ray taken on February 15, 1999 was read by Dr. Dyrud as indicative of an infiltrate in the right lung. No active cardiopulmonary disease was seen by Dr. Dyrud on March 26, 1999. The January 28, 2000 chest x-ray was found to be normal by Dr. Collie. An October 13, 2000 x-ray was reads as indicative of streak atelectasis right lung base by Dr. Sundell. A chest x-ray taken on May 4, 2001 and read by Dr. Hayden questions if there is a history of smoking or COPD, given the prominent bronchovascular markings. Dr. Sloan read a May 5, 2001 x-ray as indicative of nonspecific diffuse prominence of pulmonary vascular and interstitial markings. A chest x-ray taken on March 10, 2002 was read by Dr. Sundell as indicative of minimal streak atelectasis in the left lung base. A June 20, 2002 x-ray was read by Dr. Sundell as having findings consistent with mild to moderate bronchitis.

Dr. Ketcham read the March 24, 2004 x-ray, making no finding regarding coal worker's pneumoconiosis. (EX O). A chest x-ray taken on March 29, 2001 was read by Dr. Hayden as

[3] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. 37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. 727.206(b)(2)(iii). The symbol "BER" denotes a physician who is board eligible in radiology.

being free of infiltrate. (EX L). There was no evidence of pneumonia and no mention of pneumoconiosis.

Pulmonary Function Studies

Ex. No.	Date	Age/Ht	Physician	FEV1	FVC	MVV
DX 14	5/29/97	60/65"	Follett	2.71	3.86	
		Post-bronchodilator		2.87	4.06	
DX 14	6/13/97	60/65"	Follett	2.59	3.78	
DX 14	6/18/97	60/65"	Follett	2.48	3.34	86
		Post-bronchodilator		2.53	3.42	
DX 14	6/8/00	63/65"		2.11	2.92	
EX P	3/19/01	64/65"	Davis	2.25	3.31	
		Post-bronchodilator		2.29	3.28	
DX 11	8/21/01	65/64"	Hunter	1.73	2.24	27.0
		Post-bronchodilator		1.67	2.41	34.0
EX C	10/6/03	67/64.5"	Repsher	1.38	2.12	
		Post-bronchodilator		2.00	2.73	
CX 3	4/28/04	67/64"	Fernandez/ Solomon	1.55	2.61	
		Post-bronchodilator		1.94	2.69	

The June 18, 1997 pulmonary function study was discussed by Dr. Daryl Bindschadler. (DX 14). The FVC and FEV1 were considered to be normal and the MVV was 70% of predicted. Normal lung mechanics, mild hyperinflation, normal diffusion, mildly abnormal distribution of ventilation and normal arterial blood gases on room air at rest were noted.

Blood Gas Studies

Ex. No.	Date	Physician	PO2	PCO2
DX 14	6/18/97	Follett	65	33.0
DX 9	8/21/01	Hunter	53	35
EX C	10/6/03	Repsher	61.2	36.1
CX 4	4/28/04	Rose	60	35
		After exercise	62	35

Dr. Kennedy, who is board-certified in internal medicine, pulmonary disease and critical care medicine, found the August 21, 2001 study to be valid. (DX 10).

Medical Reports

Nearly three hundred pages of treatment records have been submitted. (DX 14). Those from Respiratory Care and Home Medical Equipment do not assist in the resolution of the issues at hand and while reviewed, will not be detailed herein. Similarly, the Vocational Evaluation and Work Capacity Evaluation from Wyoming Workers Compensation Records, which has been submitted does not assist in the initial determination of the medical issues of record. (DX 14).

Internal Medicine Group

Treatment notes from the Internal Medicine Group have been submitted. (DX 14). Those which are handwritten are illegible. In August of 1990, it was recorded that the Claimant smoked two packs of cigarettes per day. In 1992, it was noted that he had quit smoking in the last six months. In a Progress Note dated April 20, 1995, Dr. John Glode recorded that the Claimant was having occasional episodes of aching in the substernum with radiation to his right arm. He also suffered from bursitis in his left shoulder.

Dr. Joseph Follet saw the Claimant on May 29, 1997. Dr. Follett recorded that the Claimant had been complaining of increasing respiratory symptoms that mostly came and went. A cigarette smoking history of approximately seventy to eighty pack years was recorded. The spirometry was performed and it was determined that the Claimant did not have obvious spirometric proof to suggest advanced obstructive lung disease. His chest x-rays were found to show a muddy chest with some blackening although not overt coal worker's pneumoconiosis.

On June 13, 1997, Dr. Follett saw the Claimant and scheduled a complete pulmonary function study as well as a CT scan. On June 18, 1997, Dr. Follett recorded that the Claimant complained of terrible paroxysms of difficulty with breathing, coughing and choking. Dr. Follett noted that the complete pulmonary function studies showed really just small airways dysfunction, Dr. Follett observing that his lung volumes were actually quite normal as was his diffusing capacity. The CT scan showed bronchial wall thickening consistent with small airways disease related to cigarette smoking, but no evidence of any significant interstitial disease such as one would expect to see with pneumoconiosis and no advanced emphysema and no evidence of bronchiectasis or obvious changes to suggest malignancy.

In July of 1997, the Claimant was treated for infectious sinusitis. At other times, the Claimant was diagnosed as suffering from chronic obstructive pulmonary disease and other conditions including gout, fatigue, abdominal wall strain, bronchitis, laryngitis, pulmonary congestion in a many year smoker and coal worker.

A History and Physical Exam, performed on June 1, 1998, indicated that the Claimant was in for a pre-op exam. (DX 14). A chest x-ray taken on that date showed mild hyperinflation without active lung disease. The Claimant underwent a complex spinal reconstruction and

fusion. He was on oxygen therapy, which was necessitated by the surgery. In an examination of August 19, 1998, it was noted that the Claimant continued on oxygen, having been unable to be weaned since surgery. The Claimant underwent an "Impairment Rating" on August 6, 1999.

By letter dated March 19, 2001 to Dr. Diane Noton, Dr. Harmon H. Davis, II advised that the Claimant had chronic obstructive pulmonary disease and his past medical history was significant in that he had had a previous CT scan done in 1997 which showed bronchial wall thickening consistent with small airways disease, probably related to his smoking history. (CX 6). On the previous CT scan, there was no evidence of any advanced emphysema, interstitial lung disease or bronchiectasis. Dr. Davis recorded a smoking history which was actually greater than fifty pack years. Dr. Davis further noted that the Claimant had a history of twenty-five years as an open pit coal miner. The Claimant continued to have a cough. Upon examination, the Claimant had no wheezes, rales or rhonchi. Extremities revealed no clubbing, cyanosis or edema. A spirometry was performed which showed moderate small airways dysfunction with preserved lung volumes. There was no response to bronchodilator. Dr. Davis ordered a CT scan of the Claimant's chest and prescribed Combivent. He noted that by review of the Claimant's previous CT scan, he did not have coal worker's pneumoconiosis, however, Dr. Davis stated that he encouraged the Claimant to go the black lung clinic in Rock Springs.

By letter dated April 18, 2001, Dr. Harmon Davis advised Dr. Noton that the Claimant had had a chest x-ray and CT scan, which revealed evidence of pleural parenchymal scarring in his middle lobe and lingual. (CX 6, EX P). Dr. Davis stated that there was no evidence of adenopathy, recurrent pneumonia or interstitial lung disease and specifically no evidence of bronchiectasis. In view of these findings, Dr. Davis recommended that Dr. Noton treat the Claimant aggressively whenever he had a respiratory tract infection and that the Claimant be continued on Combivent. Dr. Davis also recommended that the Claimant go to the Black Lung Clinic, as he believed that it would demonstrate that he had black lung administratively and the Claimant would get some compensation.

On March 28, 2002, the Claimant underwent a Work Capacity Evaluation. (DX 14) On April 30, 2002, the Claimant was seen for follow-up of his low back and lower extremity pain.

An echocardiogram conducted on October 6, 2003 was read by Dr. Li as showing normal left ventricular size with normal function, moderate concentric hypertrophy with some asymmetry, mild mitral regurgitation and right-sided enlargement was noted, with no evidence of pulmonary hypertension. (EX G).

United Medical Center

The Claimant was hospitalized in August of 1994, complaining of chest discomfort with angina pectoris. (DX 14). He was also hospitalized on August 27, 1997, because of the recurrence of angina pectoris. (DX 14). The Impression included (1) coronary artery disease; (2) bronchitis; and (3) hyperlipidemia, on therapy. Dr. John Glode was the admitting physician.

On April 30, 2001, the Claimant was hospitalized, being discharged on May 5, 2001. It was recorded that the Claimant's history was significant for COPD, which was oxygen requiring.

A past history of heavy tobacco usage was recorded, the Claimant having smoked two to three packs per day for most of his adult life, although he stopped smoking about ten years ago. The history upon admission was taken by Dr. Kayleen Evans. Her Impression included (1) recurrent left lower lobe pneumonia; (2) chronic obstructive pulmonary disease; (3) respiratory failure secondary to above two diagnoses; (4) history of coronary artery disease, status post angioplasty; (5) diabetes mellitus, type 2, non-insulin requiring; (6) mild anemia; and (7) chronic back pain.

The Claimant was bronchoscoped, the assessment being acute bronchitis and history of recurrent pneumonia with purulent drainage from the lingular segments of the left upper lobe and history of chronic obstructive pulmonary disease with a bullous component. A bronchoscopy was performed on May 3, 2001. No malignant cells were found. The Discharge Diagnosis rendered by Dr. Harmon Davis included (1) acute pneumococcal pneumonia left lower lobe and lingula; (2) chronic obstructive pulmonary disease with history of "black lung;" (3) coronary artery disease status post angioplasty; (4) diabetes mellitus, Type II, non-insulin requiring; and (5) chronic back pain, status post previous back surgeries. His discharge medications included oxygen at 2 liters/minute 24 hours a day.

The Claimant was hospitalized on March 24, 2004, being discharged on March 31, 2004. (EX O). The discharge diagnosis by Dr. Steven Reeb included (1) left lower lobe pneumonia; (2) bronchiectasis; (3) chronic obstructive lung disease; and (4) coal worker's pneumoconiosis. The Claimant underwent a bronchoscopy on March 31, 2004. The findings by Dr. Reeb included chronic obstructive pulmonary disease with bronchiectasis/coal worker's pneumoconiosis. There was no evidence of endobronchial obstruction.

Memorial Hospital of Carbon County

Records from have been submitted which are handwritten and illegible. (DX 14). On February 15, 1999, the Claimant was seen in the Emergency Room, complaining of abdominal pain. (DX 14). Dr. V. Raja Chandra listed an initial diagnosis of (1) right lower lobe pneumonia; (2) respiratory distress; (3) gastroenteritis; and (4) right lower quadrant pain.

A hospital record from October 24, 2000, records that the Claimant was having angina pectoris again. (DX 14). On November 9, 2000, the Claimant underwent a Stress Echo Note for angina pectoris.

The Claimant was hospitalized on January 27, 2001 with a history of being increasingly short of breath with increasing cough and pneumonia. He was admitted through the Emergency Room. The diagnosis was pneumonia with hypoxia.

The Claimant was released on January 31, 2001, however, he then began feeling abdominal pain and was readmitted. On January 31, 2001, Dr. Marvin W. Couch performed a physical on the Claimant, who had been hospitalized with a chief complaint of abdominal pain. (DX 14). A smoking history of forty years at the rate of two packs per day was recorded, the Claimant presently being a non-smoker. The Assessment by Dr. Couch indicated that the Claimant had a history of multiple abdominal surgeries, and presented with abdominal pain, distention and vomiting with loose stools. A partial small bowel obstruction was suspected. In a

Progress Note dated February 2, 2001, Dr. Couch recorded that the Claimant had persistent left upper quadrant abdominal pain in epigastrium consistent with partial small bowel obstruction. A consultation by Dr. P. V. Sridharan ensued, the plan being gastrografin study for small bowel, conservative treatment. Dr. James Larsen also saw the Claimant at this time, indicating that he was being admitted with a diagnosis of (1) abdominal pain; (2) intractable diarrhea; (3) recent history of pneumonia; and (4) history of diabetes. The Discharge Diagnosis included (1) pneumonia; (2) non insulin dependent diabetes mellitus; (3) peripheral neuropathy; (4) hypercholesterolemia; and (5) arthritis. It was written by Dr. Archie Kirsch.

The Claimant was hospitalized from March 10, 2001 to March 12, 2001. The Discharge Diagnosis rendered by Dr. Couch included (1) partial small bowel obstruction; (2) pneumonia; (3) abdominal pain; and (4) vomiting.

The Claimant was hospitalized from March 10 to March 12, 2002, complaining of a severe cough and chest pressure. (DX 14). The principal diagnosis was a very mild case of pneumonia. Dr. David R. Cesko was the admitting physician. Several of the records from this admission are handwritten and illegible.

On June 20, 2002, the Claimant was hospitalized, complaining of chest pain. (DX 14). Dr. Charles C. Young recorded an Assessment which included possible low grade infiltrate in the lungs, chronic low back pain, COPD, and angina. The discharge diagnosis was resolved chest pain, COPD, chronic low back pain and lower lung infiltrate. (EX N).

Platte Valley Medical Clinic

Records from the Platte Valley Medical Clinic, dating from September 6, 2002 to April 15, 2004 reveal that the Claimant was diagnosed as suffering from numerous conditions, including pneumonia, Type II diabetes, recurrent bronchitis, chronic low back pain, gout, GERD, RAD/COPD with black lung disease from working in a coal mine and frequent recurrent lower respiratory infections, CAD status post MI in 1994 with angioplasty, shortness of breath, and sinusitis with thrush. (EX P).

Dr. Kurt Hunter

Dr. Kurt Hunter examined the Claimant on September 10, 2001. (DX 8). Dr. Hunter recorded a work history of twenty-six years and three months of coal mining and a smoking history which began at the age of twenty-eight years and ended at the age of fifty-three years, the Claimant consuming one pack of cigarettes per day. He also recorded the Claimant's chief complaints as sputum, wheezing, dyspnea, cough and paroxysmal nocturnal dyspnea. His examination included the taking of a chest x-ray, blood gas testing and pulmonary function studies. Dr. Hunter found the Claimant to be suffering from mild simple pneumoconiosis "per chest x-ray." He also found that the arterial blood gas testing showed significant abnormality regarding the Claimant's partial pressure of oxygen. The pulmonary function testing showed evidence of mild restrictive lung disease and mild obstructive lung disease. The chest x-ray showed evidence of chronic obstructive pulmonary disease and some left basilar scarring. Dr. Hunter noted that the Claimant did have a significant smoking history of twenty-five pack years

but quit smoking at the age of fifty-three years. He concluded that the Claimant had pneumoconiosis based upon his mining experience and exposure as well as his resting arterial blood gas study and pulmonary function testing. He based this finding on the abnormality upon blood gas testing, pulmonary function testing and chest x-ray. Dr. Hunter found that the Claimant met the criteria for total disability. He also found the Claimant to have a history of coronary artery disease, chronic back pain, type 2 diabetes, GERD, and hypertension.

Dr. Cecile Rose

The Claimant was seen on April 28, 2004 for assessment of possible Black Lung disease. (CX 5). Thirty years of coal mine employment was noted, as was a smoking history lasting approximately fifteen years and constituting fifty pack years. It was recorded that the Claimant had been hospitalized approximately six times for pneumonia and had been diagnosed with chronic lung disease. A physical examination was performed, as was pulmonary function and blood gas testing and a chest x-ray. Prior CT scans and other medical records were also reviewed. The Assessment rendered by Dr. Cecile Rose included (1) probable coal worker's pneumoconiosis due to approximately thirty years of coal mine dust exposure with (1) symptoms of dyspnea, cough and sputum production; (2) chest radiograph B-reading showing 1/0 bibasilar opacities; (3) abnormal arterial blood gas; and (4) abnormal spirometry. Dr. Rose also diagnosed atherosclerotic coronary artery disease, noninsulin dependent diabetes mellitus, and other conditions unrelated to coal mine dust exposure. It was the opinion of Dr. Rose that the Claimant was totally disabled based on the combination of abnormal arterial blood gas analysis, pulmonary function testing showing obstruction with a reduced diffusing capacity and cor pulmonale with right sided heart enlargement. She found the disability to be significantly related to and substantially caused by coal mine dust exposure. Dr. Rose opined that the Claimant also had a history of significant tobacco use that probably contributed to his chronic respiratory symptoms and physiologic abnormalities, "though he has avoided smoking for the past fourteen years."

Dr. Rose's deposition testimony was taken on May 21, 2004. (CX 9). Dr. Rose is board-certified in internal medicine, pulmonary medicine and occupational medicine. Dr. Rose testified that a very important part of the Claimant's history was his thirty year history of coal mine employment. Upon reviewing the x-ray reading of Dr. Lynch, Dr. Rose stated that a significant finding was that of bronchial wall thickening, which is consistent with the Claimant's report of cough and phlegm. In her opinion, the Claimant probably had a component of industrial bronchitis related to his coal mine dust exposure and probably also related to his previous smoking history. With regard to the reading rendered by Dr. Lynch, Dr. Rose stated that the findings of s/t opacities in the bases was not the typical finding for coal worker's pneumoconiosis. The majority of miners who develop black lung have small round opacities that are usually more prevalent or predominant in the upper lobes. She added, however, that a significant minority of miners develop black lung that consists of linear opacities in the lower lobes.

When reviewing the pulmonary function study conducted at the National Jewish Medical and Research Center, Dr. Rose stated that the technician and interpreting pulmonologist found the study was performed acceptably. The test itself revealed that the Claimant had normal total

lung capacity but his residual volume indicated hyperinflation, a finding seen with COPD or emphysema related to coal mine dust and/or smoking. The study also revealed that the Claimant had a component of fixed airflow limitation, which is seen in miners who develop black lung. The study also showed a diminished diffusion capacity, which also contributed to his lung impairment.

Upon reviewing the CT scan of April 29, 2004, Dr. Rose found that it revealed central bronchial wall thickening. Dr. Rose reiterated her opinion that the Claimant was suffering from coal worker's pneumoconiosis, basing this conclusion on his history of coal mine dust exposure, his clinical symptoms of cough and phlegm and shortness of breath, his chest x-ray, resting blood gas study and pulmonary function testing. She found him to have a totally disabling respiratory impairment due in part to his underlying respiratory disease from work. She based this conclusion on the blood gas and pulmonary function testing, as well as the CT scans and chest x-rays. Based upon the echocardiogram performed in October of 2003, Dr. Rose found that the Claimant had normal left heart function, however, he had right-sided heart enlargement and evidence of cor pulmonale. In this respect, she stated her disagreement with Dr. Repsher's finding that the Claimant had congestive heart failure from left ventricular failure.

Dr. Rose reviewed the report of Dr. Repsher, noting that Dr. Repsher's practice was limited to medical legal testimony on behalf of defense. Dr. Rose stated her disagreement with the finding made by Dr. Repsher, that the Claimant suffered heart failure of any type, except for right heart failure and pulmonary hypertension related to his underlying lung disease. She also stated her disagreement regarding Dr. Repsher's assessment regarding pneumonias and the increased risk to same, stating that people who have silicosis or black lung are at increased risk for bacterial pneumonias, particularly microbacterial pneumonias. Dr. Rose also disagreed with Dr. Repsher's assessment that respiratory bronchiolitis interstitial lung disease was something one saw in an individual who was an ex-smoker as opposed to a current smoker. She found it extremely unlikely that the linear opacities seen on the chest x-ray would be the result of cigarette smoking which had ceased a decade or more ago. Dr. Rose disagreed with the finding that the Claimant was in heart failure and that he did not cooperate with pulmonary function testing, as well as with the finding made by Dr. Repsher that the Claimant had normal lung function. She found no evidence of congestive heart failure on physical examination, imaging studies or echocardiograms. Dr. Rose opined that coal worker's pneumoconiosis and smoking both contributed to the Claimant's pulmonary disability.

Dr. John Glode

On December 11, 2001, Dr. Glode noted that the Claimant was now asymptomatic regarding his cardiac disease. (DX 14). In a Clinical Note dated June 27, 2002, Dr. Glode recorded that the Claimant had a pain pump with Dilaudid and took Oxycodone for chronic back pain. (DX 14).

On June 12, 2003, it was recorded by Dr. Glode that the Claimant was not having angina pectoris at this time. (CX 8). He had had a recent bout of pneumonia from which he had recovered.

In a Cardiac Clinic Note dated February 12, 2004, Dr. Glode recorded that the Claimant was contemplating back surgery and a cardiac evaluation had been ordered. (CX 7). The chest was clear and the heart was negative for murmurs and gallops. There was no edema and the peripheral vasculature was intact.

By report dated July 24, 2004, Dr. Glode stated that he had been asked to render an opinion regarding the current cardiovascular status of the Claimant. (CX 10). Dr. Glode stated that the Claimant was diagnosed with coronary artery disease in 1994 and after angioplasty that same year, his coronary disease had been stable. In 2000, the Claimant had chest discomfort compatible with angina pectoris but a stress echo demonstrated no evidence of ischemia or angina pectoris on the treadmill. He noted that the Claimant had developed significant dyspnea on exertion and has been diagnosed with COPD and black lung disease. While Dr. Repsher found the Claimant's dyspnea to be due to coronary disease and diastolic heart failure, Dr. Repsher based this conclusion on evidence of left ventricular hypertrophy and relaxation disorder on a remote echocardiogram. According to Dr. Glode, a subsequent echocardiogram interpreted by Dr. Li revealed that the Claimant's left ventricular systolic function was normal and there was no evidence of a significant pulmonary hypertension. According to Dr. Glode, the Claimant was not currently having angina pectoris and he had no evidence of heart failure or other complications from his coronary disease and hypertension during an examination conducted on February 12, 2004. Dr. Glode is board-certified in internal medicine and cardiology.

Dr. Glode stated his disagreement with Dr. Repsher's assessment that because the Claimant has left ventricular hypertrophy with relaxation disorder he must also have diastolic heart failure. Dr. Glode opined that most patients with early diastolic dysfunction of the heart do not have heart failure and many patients with essential hypertension have mild left ventricular hypertrophy with relaxation disorder and are totally asymptomatic. Dr. Glode found that the Claimant had significant pulmonary dysfunction by objective testing and this was certainly the most likely cause of the Claimant's dyspnea on exertion. While Dr. Repsher found that the Claimant's audible rales were suggestive of heart failure, Dr. Glode pointed out that there are many causes of rales other than heart failure, rales being a nonspecific finding. The diagnosis of heart failure must be supported by other objective evidence, according to Dr. Glode and he found that the Claimant did not have rales on his last examination of the Claimant, which was on February 12, 2004.

Dr. Lawrence R. Repsher

Dr. Lawrence R. Repsher saw the Claimant on October 6, 2003. (EX A). Dr. Repsher recorded twenty-one to twenty-two years of coal mine employment. He noted that the Claimant indicated he was "never a heavy smoker," although records indicated otherwise. Dr. Repsher found that the chest x-ray showed no evidence of coal worker's pneumoconiosis and found the CT scan to show some focal scarring in the right middle lobe and the left lung base, but to otherwise be normal. The pulmonary function tests were uninterpretable due to extremely poor effort and cooperation. He found, however, that the effort independent testing was normal, suggesting no significant intrinsic lung disease, despite the Claimant's long and heavy cigarette smoking habit. Based upon his examination, Dr. Repsher found no evidence of coal worker's pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or

aggravated by his employment as a coal miner. Dr. Repsher did find the Claimant to be suffering from coronary artery disease, chronic hypertension, chronic low back pain, recurrent pneumonias, hyperlipidemia and noninsulin dependent diabetes mellitus. Dr. Repsher based his finding on the fact that the x-ray evidence was negative for coal worker's pneumoconiosis, and the Claimant had no pulmonary function test or blood gas evidence of coal worker's pneumoconiosis. Dr. Repsher is board-certified in internal medicine, pulmonary disease and critical care medicine.

The deposition testimony of Dr. Repsher was taken on May 3, 2004. (EX R). Dr. Repsher testified that he evaluated the Claimant on October 6, 2003, having also had the opportunity to review a lot of the Claimant's medical records. Dr. Repsher testified that the Claimant was on oxygen and using nitroglycerin tablets at a modest rate. He had a history of heart surgery, diabetes and high blood pressure, COPD from smoking and gastroesophageal reflux disease as well as low back pain that was not improved by surgery. The echocardiogram of 2000 revealed that he had hypertensive heart disease. Dr. Repsher explained that he obtained the Claimant's past medical history partially from the Claimant and primarily from a review of medical records. While he listed COPD and emphysema as well as black lung in his report, the source of the former two was the records while the latter came from the Claimant. Dr. Repsher testified that his review of the chest x-ray revealed small opacities which were indicative of respiratory bronchiolitis interstitial lung disease, which is what is seen in a person who has been a long and heavy cigarette smoker. The CT scan showed no evidence of pneumoconiosis. Dr. Repsher reiterated that the pulmonary function tests were uninterpretable as the Claimant failed to make reasonable effort whatsoever to cooperate with the technician's instructions on testing. While blood gas testing was performed, Dr. Repsher found that these did not assist in a determination of lung function, because the Claimant was in heart failure at the time the test was done. Dr. Repsher reiterated his opinion that the Claimant did not suffer from coal worker's pneumoconiosis or any respiratory condition related to his work as a coal miner. In his opinion, the Claimant's symptoms of shortness of breath were most likely due to his coronary artery disease and hypertensive cardiovascular disease. Dr. Repsher stated that the Claimant was in left ventricular heart failure as a result of two forms of organic heart disease" coronary artery disease and hypertensive cardiovascular disease. Dr. Repsher opined that the Claimant probably had a mild COPD, however, he could not be certain because of the Claimant's failure to cooperate with testing.

The deposition testimony of Dr. Repsher was continued on June 15, 2004. (EX S). Dr. Repsher testified that he had reviewed the medical report of Dr. Cecile Rose. Dr. Repsher stated that he and Dr. Rose did not have a cordial relationship due to the fact that, in his opinion, Dr. Rose ignored the medical facts and relied much more heavily on what a patient tells her than the objective medical facts. With regard to the statement made by Dr. Rose, that Dr. Repsher's medical practice was limited to medical legal testimony on behalf of insurance companies or defense attorneys, Dr. Repsher stated that it was a lie. When asked to review the medications listed by Dr. Rose in her report, Dr. Repsher stated that some of those medications are customarily prescribed by physicians for asthma and some, Zestril and Metoprolol, were for hypertension or high blood pressure. Zestril causes a cough in about one-third of the patients that take it and Metoprolol can make asthma worse, if the patient has asthma. In a patient with asthma, Metoprolol can cause coughing, wheezing and shortness of breath. Dr. Repsher testified

that diabetes, and poorly controlled diabetes in particular, results in a much higher risk for infections of all types, including those of the respiratory tract or urinary tract. Dr. Repsher opined that individuals with COPD are at a much higher risk of developing bacterial pneumonias following what would otherwise be a common cold in other individuals. Typical symptoms of bacterial infections include fever, cough, and discolored sputum. According to Dr. Repsher, linear opacities on chest x-ray are due to cigarette smoking. Dr. Repsher disagreed with the opinion rendered by Dr. Rose, that the Claimant suffered from coal worker's pneumoconiosis. In explaining his disagreement, Dr. Repsher stated as follows:

> …the clinical symptoms of cough and phlegm and shortness of breath are non-specific, but are seen in most patients who have been long and heavy cigarette smokers, like Mr. Russell.

Dr. Repsher went on to note that the blood gas studies do not help with a diagnosis of a condition, while the pulmonary function test showed that the Claimant had airflow limitation, hyperinflation and decreased diffusion capacity, which are typical findings in cigarette smokers. The finding of hyperinflation would be the opposite of that which one would expect to see in clinically significant coal worker's pneumoconiosis. Dr. Repsher also disagreed with the statement made by Dr. Rose that the Claimant had cor pulmonale and right-sided enlargement, since, in his opinion, the most common cause of cor pulmonale is left-sided heart failure. Contrary to the finding made by Dr. Rose, Dr. Repsher did find evidence of congestive heart failure in his physical examination of the Claimant, more specifically left ventricular congestive heart failure. The latter condition was the main reason the Claimant was short of breath.

On cross-examination, Dr. Repsher stated that the x-ray reading by Dr. Lynch was not positive for coal worker's pneumoconiosis because it did not indicate rounded opacities in the upper lobes. According to Dr. Repsher, left ventricular hypertrophy coupled with rales equals heart failure on the left side, in most cases. When reviewing the pulmonary function study conducted by Dr. Hunter, Dr. Repsher opined that the Claimant had a lack of effort on those tests. He also found the study conducted on April 28, 2004 to be invalid due to poor patient effort. Dr. Repsher stated that the blood gas study he conducted on the Claimant was not acceptable because the Claimant was in heart failure at the time of the study.

CT Scans

A CT scan of the chest was performed on June 18, 1997. (DX 14). Dr. James G. Hubbard noted (1) a few scattered middle mediastinal lymph nodes, none reach criteria for adenopathy; (2) heart size, upper limits of normal; (3) bronchial wall thickening, consistent with some element of chronic bronchitis; (4) atelectasis or scarring in the right middle lobe medially; (5) fatty infiltration in the liver which is minimal; (6) left renal cyst; (7) status post cholecystectomy; (8) multiple metallic densities are identified in the abdomen consistent with surgical clips; and (9) degenerative changes of the spine.

A CT scan taken on February 15, 1999 of the abdomen and pelvis listed as part of the Impression, "infiltrates in the right lung." (DX 14). The radiologist was Dr. James Dyrud.

A CT scan of the thorax was performed on March 29, 2001. (DX 14). No evidence of interstitial lung disease was found, nor was any evidence of bronchiectasis found. Small Pleural pericardial areas of scarring in the lingual and the middle lobe were noted. The Impression noted by Dr. Scott Hayden was (1) small band-like area of parenchymal opacity is present (probably is one of atelectasis or scarring), which arises from the pericardium, extends through the lingula and abuts the pleural surface with smaller areas of focal pleural thickening 1 cm above this level and also in the middle lobe along the pericardial reflection; (2) no central obstructive lymphadenopathy is seen; (3) no evidence for recurrent pneumonia, non-specific pleural parenchymal scarring, no mass lesion identified; and (4) no evidence for interstitial lung disease.

On October 6, 2003, a high resolution computerized tomography of the chest was performed. (EX E). Focal scarring could be seen in the right middle lobe and lingula as well as within the left lung base laterally. Some diffuse increased density areas in both lungs without focal mass effect were also noted, the reading having been performed by Dr. Walker

Dr. John Armstrong, a board-certified radiologist, indicated that he reviewed the CT scan from March 29, 2001 as well as two CT scans from March of 2004. (EX I). He found the central airways bronchial wall thickening to be suggestive of bronchitis or asthma, further finding bibasilar, left greater than right, centrilobular nodularity and interlobular septal thickening which would be unusual for coal worker's pneumoconiosis. An alternative explanation could be recurrent or chronic aspiration, which more recently was associated, perhaps, with left lower lobe pneumonia. He specifically found no evidence of upper lobe nodularity conglomerate masses or emphysema to suggest coal worker's pneumoconiosis.

On March 24, 2004, a CT scan was performed and read by Dr. William D. Ketcham as indicative of (1) left lower lobe pneumonia; (2) mediastinal adenopathy; (3) scattered pleural based and intraparenchymal nodules do not appear calcified and are therefore indeterminate; (4) atherosclerotic and coronary artery disease; (5) small left renal cyst, eccentric. (EX O).

A CT scan performed on March 27, 2004 was interpreted by Dr. Hayden as indicative of COPD with atelectasis, subsegmental in the left lower lobe. (EX 0).

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by

dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201.

20 C.F.R. § 718.202(a) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Claimant had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions.

Only one x-ray was read as positive for pneumoconiosis. The remaining three readings done specifically for determining the existence of pneumoconiosis, were negative. The numerous x-ray readings taken during treatment of the Claimant were silent as to the disease.

Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays must be considered (§718.202(a)(1)). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers qualifications. *Goss v. Eastern Associated Coal Co.*, 7 BLR 1-400 (1984). Readings by physicians, who are both board-certified radiologists and B-readers are generally entitled to the greatest weight. *Roberts v. Bethlehem Mines Corporation,* 8 BLR 1-211 (1985); *Sheckler v. Clinchfield Coal Company,* 7 BLR 1-128 (1984). Dr. Lynch, a B-reader and board-certified

radiologist, found the April 28, 2004 x-ray to be positive. Dr. Repsher, a B-reader found the x-ray to be negative. Dr. Webber a board-eligible radiologist found the August 21, 2001 x-ray to be negative as well. As noted, numerous x-rays taken during treatment, were silent on the issue.

Upon careful review of the x-ray evidence of record, I find that the positive reading by the most highly qualified physician of record outweighs the contrary evidence of record. While Dr. Repsher, a B-reader, read the two x-rays he reviewed as negative, he is not a board-certified radiologist. Accordingly, based upon the positive reading by Dr. Lynch, of the most recent x-ray of record, I find that the x-ray evidence is sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1). While there was testimony that the opacities found were not the type to be seen with coal worker's pneumoconiosis, this does not negate the fact that the regulations provide for a positive reading upon the finding of opacities as found in this case.

I must next consider the medical opinion evidence. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields,* above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984).

Initially, the Claimant's smoking history must be assessed in determining the weight to be given to the medical opinions of record. Thus, the Claimant testified that he smoked a carton of cigarettes per month. Medical records, however, indicate a smoking history of as much as three packs per day for most of his adult life. Based upon the evidence of record, I find that the Claimant smoked two packs per day for thirty years.

Upon reviewing the medical evidence of record, it is noted that the Platte Valley Medical Clinic records list black lung as a condition suffered by the Claimant, with no indication as to how that diagnosis was reached. Records from the United Medical Center indicate a history of black lung in 2001 while a record from Dr. Reeb lists coal worker's pneumoconiosis. Records from Memorial Hospital of Carbon County do not list coal worker's pneumoconiosis or black lung. COPD, however, is recorded. In the Internal Medicine Group records from 1997, Dr. Follett found the Claimant's lung volumes to be actually quite normal, bronchial wall thickening consistent with small airways disease related to cigarette smoking and no evidence of any significant interstitial disease such as one would expect with a pneumoconiosis. The treatment records from the Internal Medicine Group also include records from Dr. Davis, who found conditions related to the Claimant's smoking history. In March of 2001, Dr. Davis found no evidence of interstitial lung disease and while he did not find that the Claimant suffered from

coal worker's pneumoconiosis, he encouraged the Claimant to go to the Black Lung Clinic. In April of 2001, Dr. Davis again recommended that the Claimant go to the Black Lung Clinic, as he believed that the Claimant had black lung "administratively." Thus, Dr. Follett specifically rules out coal worker's pneumoconiosis, while Dr. Davis does not specifically diagnose the disease, indeed, finding same to be absent at one point in his report. Dr. Davis does not provide any medical explanation why he encouraged the Claimant to go to the Black Lung Clinic, other than the hope of receiving compensation.

Dr. Hunter diagnoses coal worker's pneumoconiosis based on the chest x-ray. He also notes that the Claimant has a significant smoking history as well as a twenty-five year history of coal mine employment. Dr. Hunter then concludes that the Claimant has pneumoconiosis based on his mining experience as well as his pulmonary function and blood gas testing results. Dr. Hunter fails, however, to explain how the blood gas and pulmonary function testing establish the etiology of the Claimant's pulmonary condition. He appears to rely solely on the Claimant's years of coal mine dust exposure and a positive chest x-ray, therefore, to determine the etiology of the Claimant' pulmonary condition. In *Cornett v. Benham Coal Inc.,* 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute "sound" medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 BLR 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 BLR 1-405 (1985)). In *Taylor*, the Board stated that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id*. Given that Dr. Hunter relies primarily upon those two factors to diagnose pneumoconiosis, I find that his report neither well-reasoned nor well-documented. It should also be noted that Dr. Hunter relies on a smoking history which is significantly less than that found by me.

The medical opinion evidence of Dr. Glode is significant in its assessment of the Claimant's heart disease, not however, on the issue of the existence of pneumoconiosis. Dr. Glode's notation that the Claimant had been diagnosed with COPD and black lung disease appears to be no more than a recitation of past history and not a reasoned medical opinion rendered by Dr. Glode. Therefore, it cannot assist the Claimant in establishing pneumoconiosis pursuant to §718.204(a)(4).

The CT scans appear to affirmatively find coal worker's pneumoconiosis to be absent. This leaves the medical opinions of the dueling experts, Drs. Repsher and Rose. Dr. Repsher finds coal worker's pneumoconiosis to be absent. Dr. Rose finds probable coal worker's pneumoconiosis, also finding the Claimant to be disabled due to coal mine dust exposure, basing the finding of disability on the arterial blood gas and pulmonary function testing and cor pulmonale with right sided heart enlargement. Dr. Rose's initial diagnosis of coal worker's pneumoconiosis is equivocal at best, given that she finds "probable" coal worker's pneumoconiosis. As such, it is insufficient to meet the Claimant's burden of proof in this matter. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Her subsequent assessment, that the Claimant's disability is due, in part to coal mine dust exposure, is not adequately supported by

reasoning or documentation. Thus, the CT scan evidence consistently shows coal worker's pneumoconiosis to be absent and the finding of scarring to be the result of chronic bronchitis or chronic aspiration. Dr. Rose states that she relies on the chest x-rays and CT scans to find coal worker's pneumoconiosis, as well as the arterial blood gas and pulmonary function testing. Pulmonary function and blood gas testing do not address etiology. The x-ray evidence, being the reading by Dr. Lynch, produced a reading of opacities that are not typically found in coal worker's pneumoconiosis. While Dr. Rose agrees with this assessment, she states that a minority of miners will have the type of opacities found by Dr. Lynch, failing to explain how she can determine that this is the case herein, or how she rules out cigarette smoking as the etiology. Indeed, as with Dr. Hunter, Dr. Rose also relies upon a cigarette smoking history which is significantly less than that found by me.

Dr. Rose's reliance on CT scans appears to be misplaced, given the consistently negative readings of those. Dr. Armstrong, a board-certified radiologist, reviewed the CT scan evidence, finding them to have characteristics which are highly unusual for coal worker's pneumoconiosis. It is these very findings which Dr. Rose stated established the existence of the disease, a finding which is not persuasive in light of the contrary evidence of record. Finally, Dr. Rose's stated reliance on the Claimant's symptoms of cough and phlegm and shortness of breath also fails to adequately explain how tobacco abuse or other conditions suffered by the Claimant, can be ruled out as the etiology of these nonspecific findings. She fails to effectively explain how these symptoms can be traced to coal mine dust exposure as opposed to the Claimant's other ailments or to adequately take into account the other conditions from which the Claimant suffers, in assessing his pulmonary disability and its etiology. For these reasons, I do not find her opinion to be well-reasoned or well-documented.

In sum, when weighing the medical opinion evidence of record, I find that evidence insufficient to meet the Claimant's burden of proof. Therefore, I find that the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4) has not been established.

Total Disability

In order to be entitled to benefits, the Claimant must also establish the existence of total disability due to pneumoconiosis, in order to be entitled to benefits. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(i)and (ii).

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. §§ 921(c)(3), 20 C.F.R. § 718.304, or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner’s claim, a finding of total disability due to

pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) ; *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Claimant suffers from complicated pneumoconiosis or cor pulmonale with right-sided congestive heart failure. While Dr. Rose found cor pulmonale, she did not diagnosed right-sided congestive heart failure. Left to be considered are the pulmonary function studies, blood gas studies and medical opinions.

All relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp*., 9 BLR 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 BLR 1-231, 1-232 (1987). Furthermore, the Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 BLR 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where a pulmonary function tests demonstrate FEV1[4] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[5] or MVV[6] values equal to or less than the applicable table values. Alternatively, a qualifying FEV1 reading together with an FEV1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. §718.204(b)(2)(i) and Appendix B. Assessments of these results is dependent on the Claimant's height which was recorded as 64, 64.5, and 65 inches. Considering this discrepancy, I find the Claimant's height to be 64.6 inches for the purposes of evaluating the pulmonary function studies. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). The study conducted pre-bronchodilator by Dr. Repsher on October 6, 2003 produced qualifying values, however, he found the study to be invalid due to poor effort. Based upon the preponderance of non-qualifying studies, I find that the evidence insufficient to establish total disability pursuant to 20 C.F.R. §718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. In this case the blood gas studies conducted on August 21, 2001 and at rest on April 28, 2004, produced qualifying values. The preponderance of the studies, however, including the after-exercise study conducted on April 28, 2004, failed to produce values indicative of total disability. Accordingly, find that evidence insufficient to establish total disability pursuant to this subsection.

Section 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory

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[4] Forced expiratory volume in one second

[5] Forced vital capacity

[6] Maximum voluntary ventilation

diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. It is apparent from the treatment records, that the Claimant suffers from chronic bronchitis and chronic obstructive pulmonary disease, as well as pneumonias. At one point, he was on oxygen for an extended period of time. The treatment records do not render an opinion regarding disability. Drs. Rose and Hunter found pulmonary disability. Dr. Repsher did not, finding at most a mild chronic obstructive pulmonary impairment. Based upon the treatment records and the opinions of Drs. Hunter and Rose, I find that total disability has been established pursuant to 20 C.F.R. §718.204(b)(iv).

Having found the existence of total disability by means of the medical opinion evidence, I must now weight the contrary probative evidence of record. In so doing, I conclude that the contrary probative evidence of record is insufficient to outweigh same. Accordingly, I find that the existence of total disability has been established pursuant to 20 C.F.R. §718.204(b).

Total Disability Due to Pneumoconiosis:

In order to be entitled to benefits, the Claimant must establish total disability due to pneumoconiosis pursuant to §718.204(c)(1). Total disability due to pneumoconiosis requires that pneumoconiosis as defined in §718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." §718.204(c)(1)(i) &(ii). Absent a showing of cor pulmonale or that one of the presumptions of §718.305 are satisfied, it is not enough that a miner suffer from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. *See* §718.204(c)(2). Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. *Id.*

When reviewing the medical evidence of record, and for the reasons noted above, I find that evidence insufficient to establish that the pulmonary disability suffered by the Claimant is due to pneumoconiosis. In this respect, I find the opinions of Drs. Rose and Hunter, with regard to the etiology of the Claimant's condition, to be less than well-reasoned or well-documented. Indeed, in finding coal mine dust exposure to be a contributor to the Claimant's pulmonary condition, Dr. Rose stated that tobacco use "probably" contributed to his chronic respiratory symptoms, "though he has avoided smoking for the past fourteen years." As noted, both Drs. Rose and Hunter rely on a smoking history which is significantly less than that which was found by me. Both physicians fail to adequately explain how they are able to determine the etiology of the pulmonary impairment, or more specifically, that coal mine dust exposure was a factor, and in the case of Dr. Rose, that tobacco use was only a "probable" factor. In the case of Dr. Rose, the findings upon which she relies to find coal worker's pneumoconiosis on CT scan were those specifically found by other physicians, such as Dr. Armstrong, to rule out the existence of the disease.

When reviewing the totality of the evidence herein, I find that that evidence fails to establish that the Claimant is totally disabled due to pneumoconiosis pursuant to §718.204(c)(1).

No evidence of cor pulmonale with right-sided congestive heart failure or evidence satisfying the presumptions of §718.305 has been offered. As noted above, I find that the opinions of Drs. Hunter and Rose are insufficient to meet the Claimant's burden of proof on this issue. While the Claimant has twenty-two years of coal mine dust exposure he also has a significant history of tobacco abuse and other conditions, which it has been plausibly explained, can cause the respiratory symptoms from which he suffers. It is the failure to adequately explain and document how these symptoms can be linked to coal mine dust exposure as opposed to those other conditions from which he suffers that render the opinions of Drs. Hunter and Rose deficient. Accordingly, I find that the evidence fails to affirmatively establish total disability due to pneumoconiosis as required by 20 C.F.R. §718.204(c).

Entitlement

Claimant has failed to meet his burden to establish that he suffers from pneumoconiosis and is totally disabled thereby. Therefore, he is not entitled to benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim of Blain Russell for benefits under the Act is DENIED.

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RICHARD K. MALAMPHY
Administrative Law Judge

RKM/ja
Newport News, Virginia

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this Notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.